Analysis of Medicaid Reimbursement Rates for Acute Hospitals, Nonacute Hospitals, and Community Health Centers in Massachusetts

Report Summary

Keith Hearle, M.B.A.

Allen Dobson, Ph.D.

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Study methods

- Data analysis:
  - American Hospital Association (AHA) Annual Survey Data
  - Medicare Cost Report Data
  - Division of Health Care Policy and Finance (DHCFP) 403 Cost Reports
  - Other analyses prepared by DMA, DHCFP, and MHA
- Acute care hospital survey
- 42 usable responses
- 62% response rate
- Hospital Efficiency Model
- Analysis of Medicaid rate setting methodologies
- Interviews
- Interaction with a Steering Committee

Introduction to the Massachusetts Medicaid program

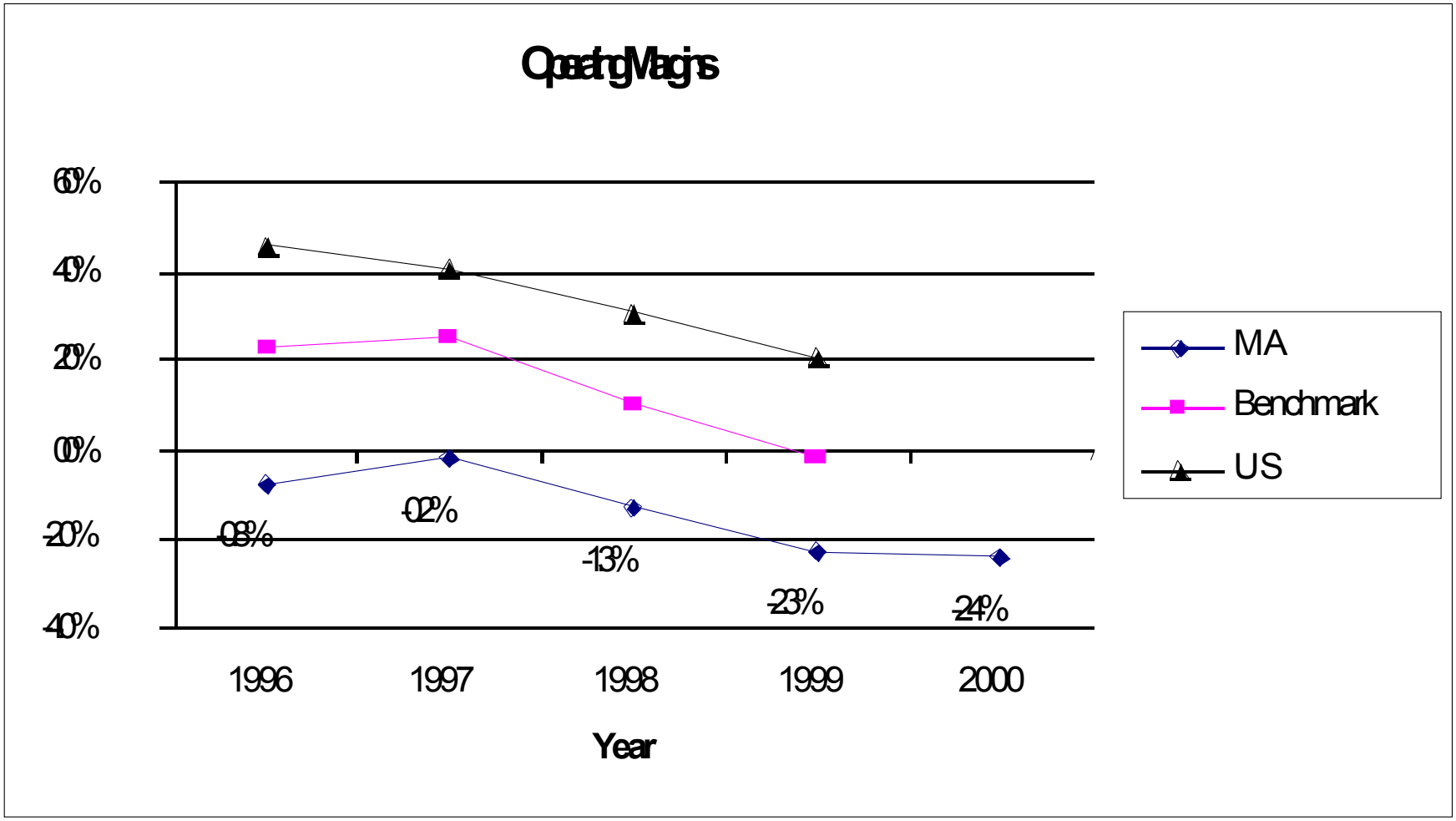
- The program provides health care benefits to over 900,000 residents of the Commonwealth, an increase from 687,000 in June 1997.
- Fiscal Year 2000 Expenditures:
  - $4.4 billion total
  - 17.5 percent for fee-for-service acute hospital, non-acute hospital, and community health centers
  - Annual growth of 5.9 percent for total budget, below 3.0 percent for these providers
  - Per-beneficiary expenditure growth below 2.0 percent annually
- Approximately 80 percent of acute hospital funds paid through fee-for-service (administered prices) rates established by DMA and DHCFP; 20 percent through Medicaid managed care.

Average Medical Assistance Spending per Enrollee by State in 1998 (Includes all Medical Expenses and Long Term Care 1/ 2/ 3/

Rank	State	Average Expense per Eligible	Rank	State	Average Expense per Eligible
1	NEW YORK	$8,825	27	NEVADA	$5,082
2	NEW HAMPSHIRE	$8,377	28	MICHIGAN	$4,926
3	NORTH DAKOTA	$7,547	29	NORTH CAROLINA	$4,746
4	CONNECTICUT	$7,458	30	KENTUCKY	$4,600
5	RHODE ISLAND	$7,457	31	OREGON	$4,558
6	WISCONSIN	$6,564	32	HAWAII	$4,433
7	**MASSACHUSETTS**	**$6,523**	33	WEST VIRGINIA	$4,421
8	NEW JERSEY	$6,479	34	ARKANSAS	$4,401
9	MAINE	$6,463	35	LOUISIANA	$4,341
10	MINNESOTA	$6,438	36	MISSOURI	$4,319
11	MONTANA	$6,126	37	ILLINOIS	$4,313
12	DISTRICT OF COLUMBIA	$6,014	38	TEXAS	$4,287
13	WYOMING	$5,862	39	FLORIDA	$4,262
14	SOUTH DAKOTA	$5,826	40	WASHINGTON	$4,168
15	KANSAS	$5,804	41	OKLAHOMA	$4,074
16	COLORADO	$5,731	42	VIRGINIA	$4,007
17	OHIO	$5,691	43	NEW MEXICO	$3,940
18	PENNSYLVANIA	$5,660	44	ALABAMA	$3,888
19	ALASKA	$5,638	45	ARIZONA	$3,792
20	IOWA	$5,546	46	MISSISSIPPI	$3,754
21	IDAHO	$5,542	47	VERMONT	$3,495
22	MARYLAND	$5,433	48	SOUTH CAROLINA	$3,443
23	INDIANA	$5,412	49	GEORGIA	$3,356
24	NEBRASKA	$5,350	50	TENNESSEE	$2,959
25	UTAH	$5,233	51	CALIFORNIA	$2,777
26	DELAWARE	$5,110		Total US	$4,820

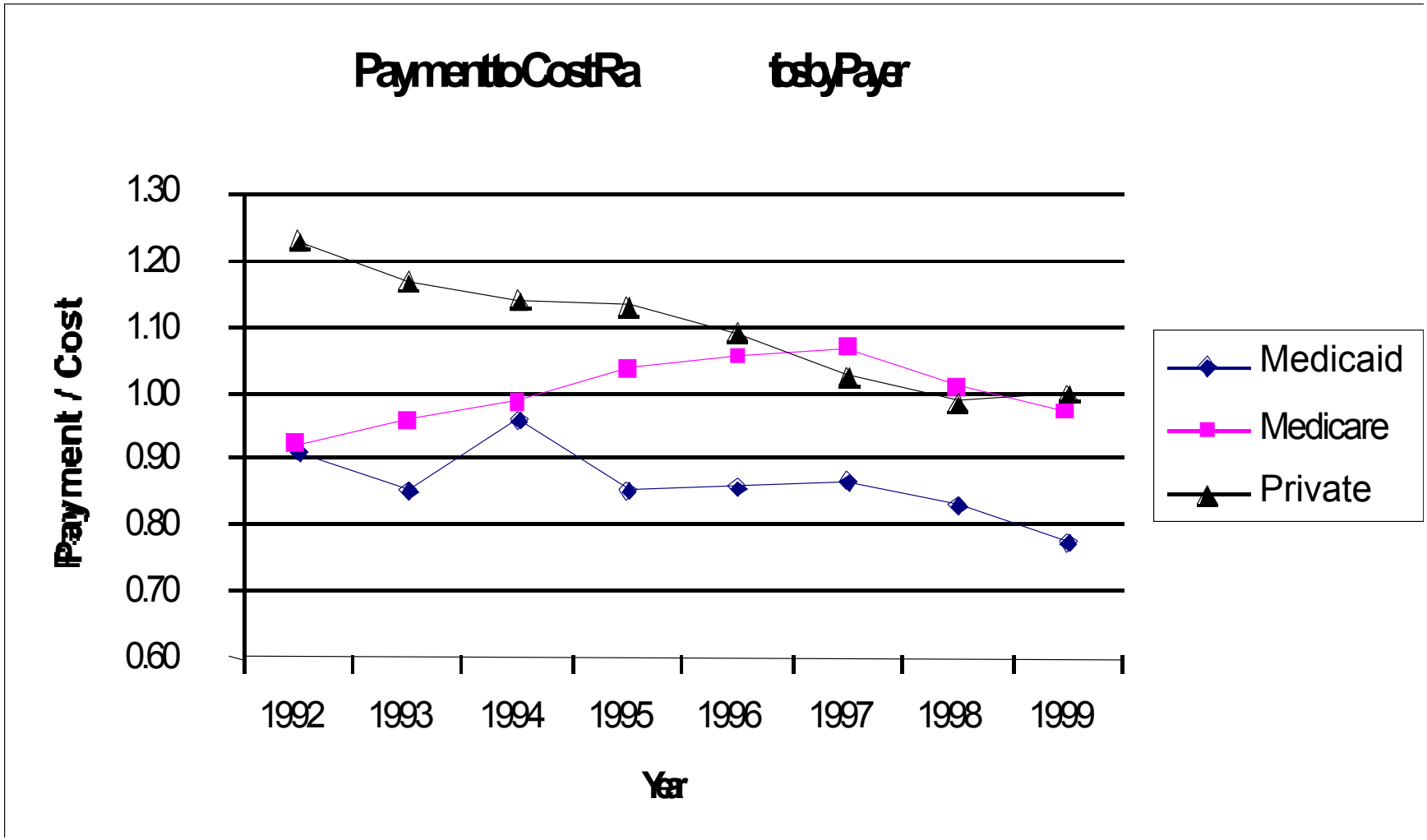
1/ Number of Enrollees computed on an average monthly basis.
2/ Includes spending for all medical services and long term care and excludes DSH payments. DSH payments were excluded because of the wide variation DSH payment amounts across states.

Financial condition



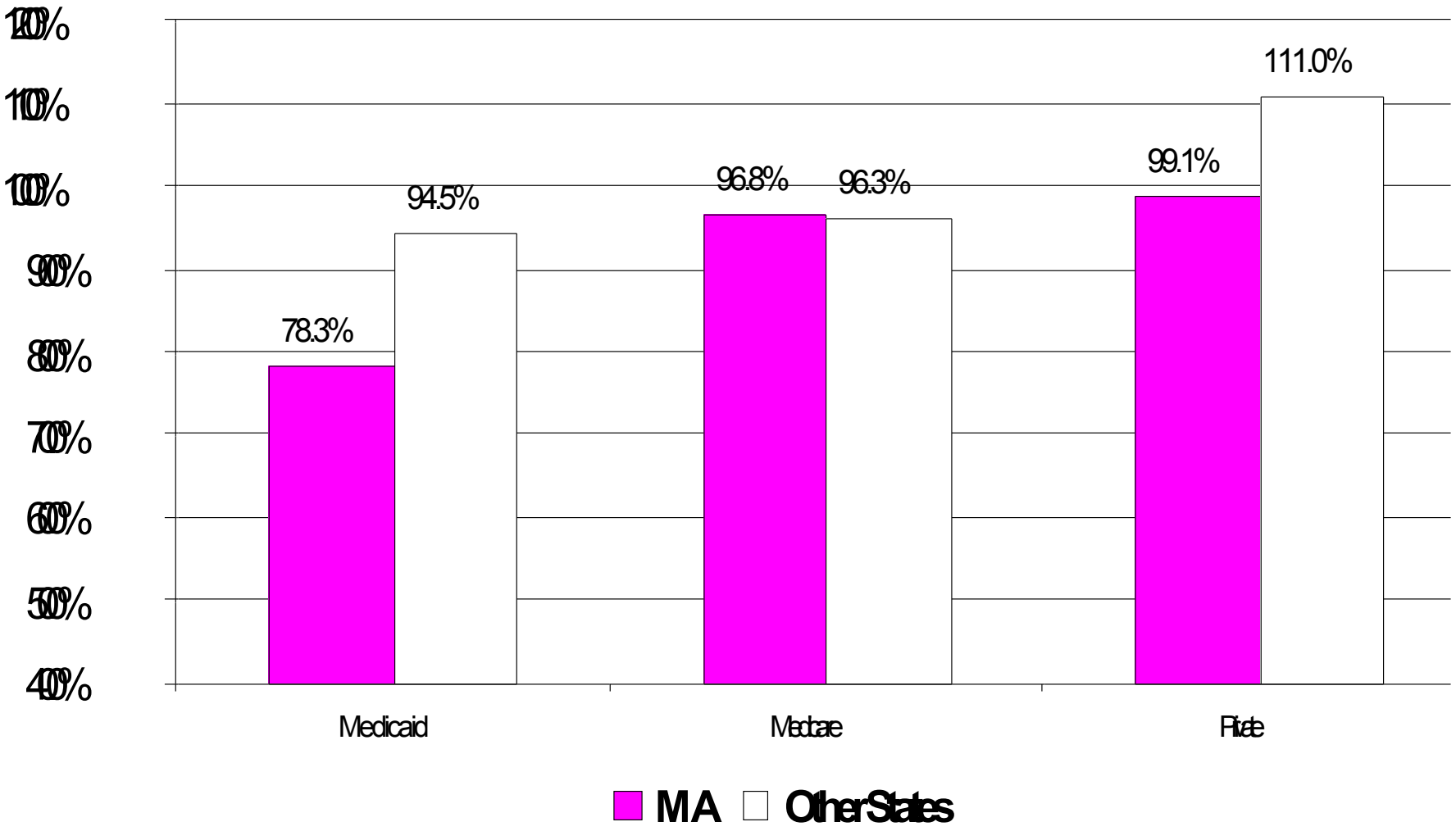
Sources: U.S. and Benchmark states – American Hospital Association Annual Survey of Hospitals. Massachusetts 1996 through 1999: The Massachusetts Division of Health Care Finance and Policy. Massachusetts 2000: The Massachusetts Hospital Association annual survey of hospitals.

Acute care hospital "payment to cost" relationships



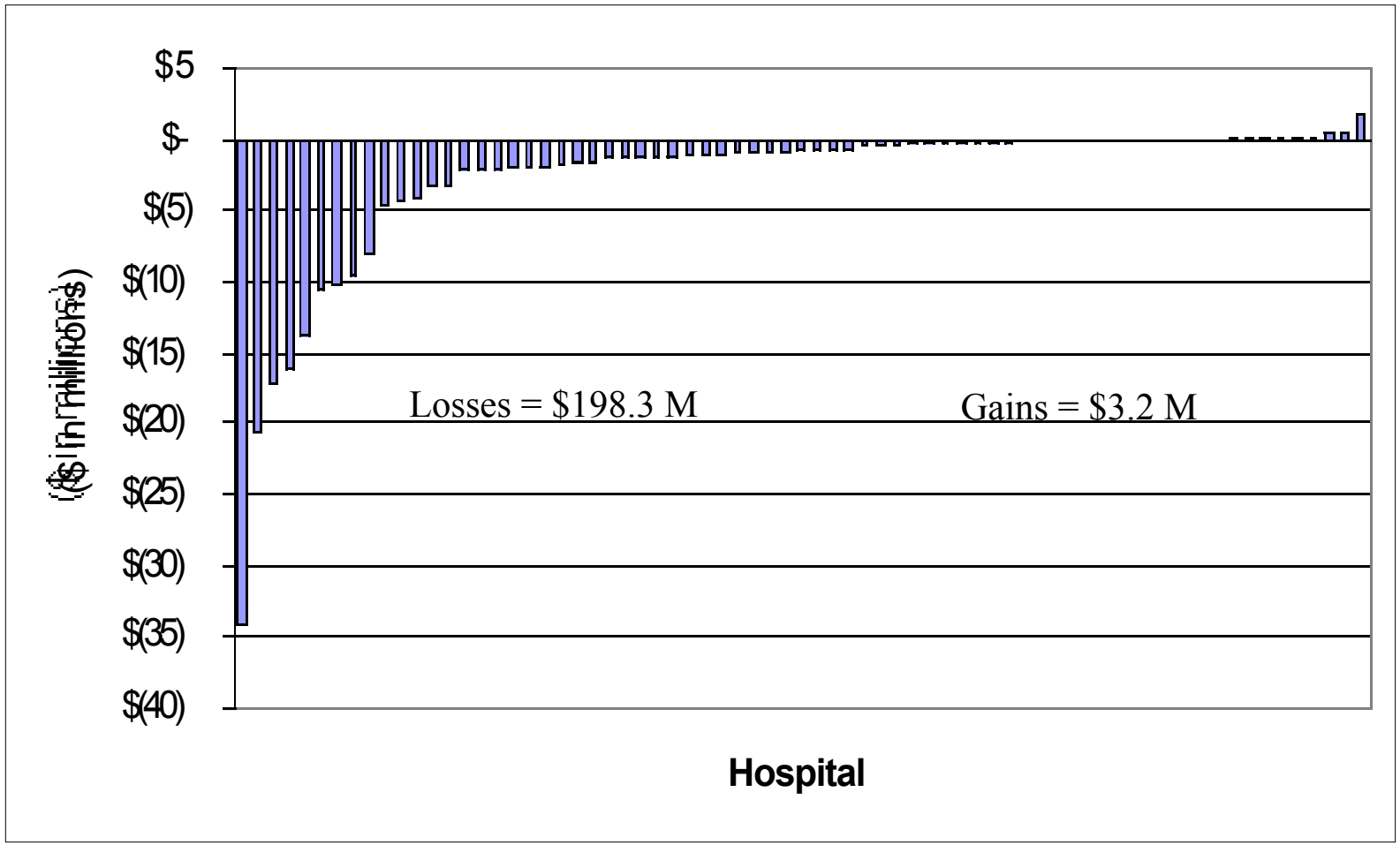
Source: American Hospital Association Annual Survey, 1992 - 1999.

Payment to Cost Ratios for all hospitals, MA versus Comparison States, 1999 (AHA)



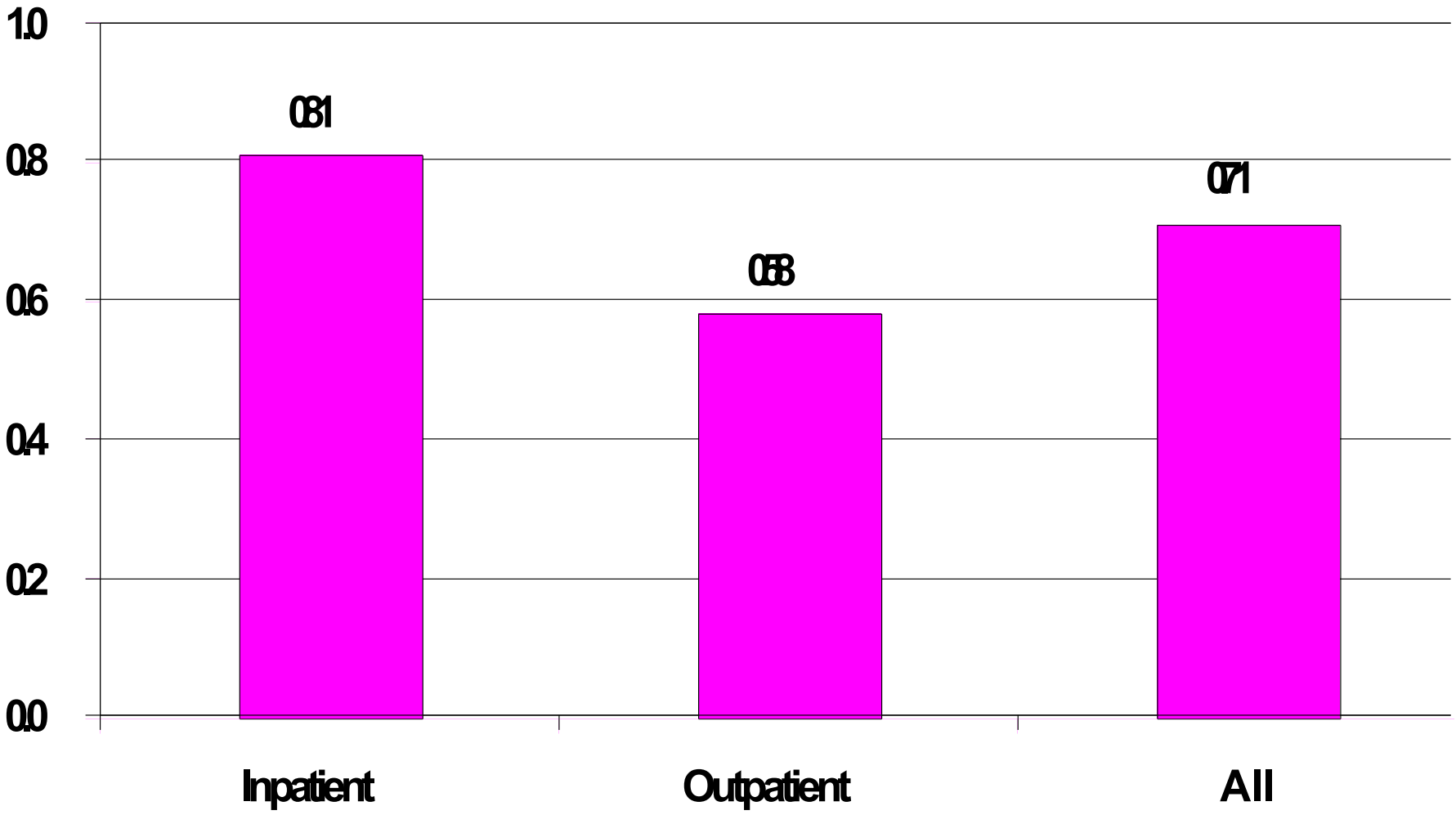
Source: Lewin Group Analysis of AHA Hospital Survey Data.

Acute care hospital Medicaid losses or gains, 1999



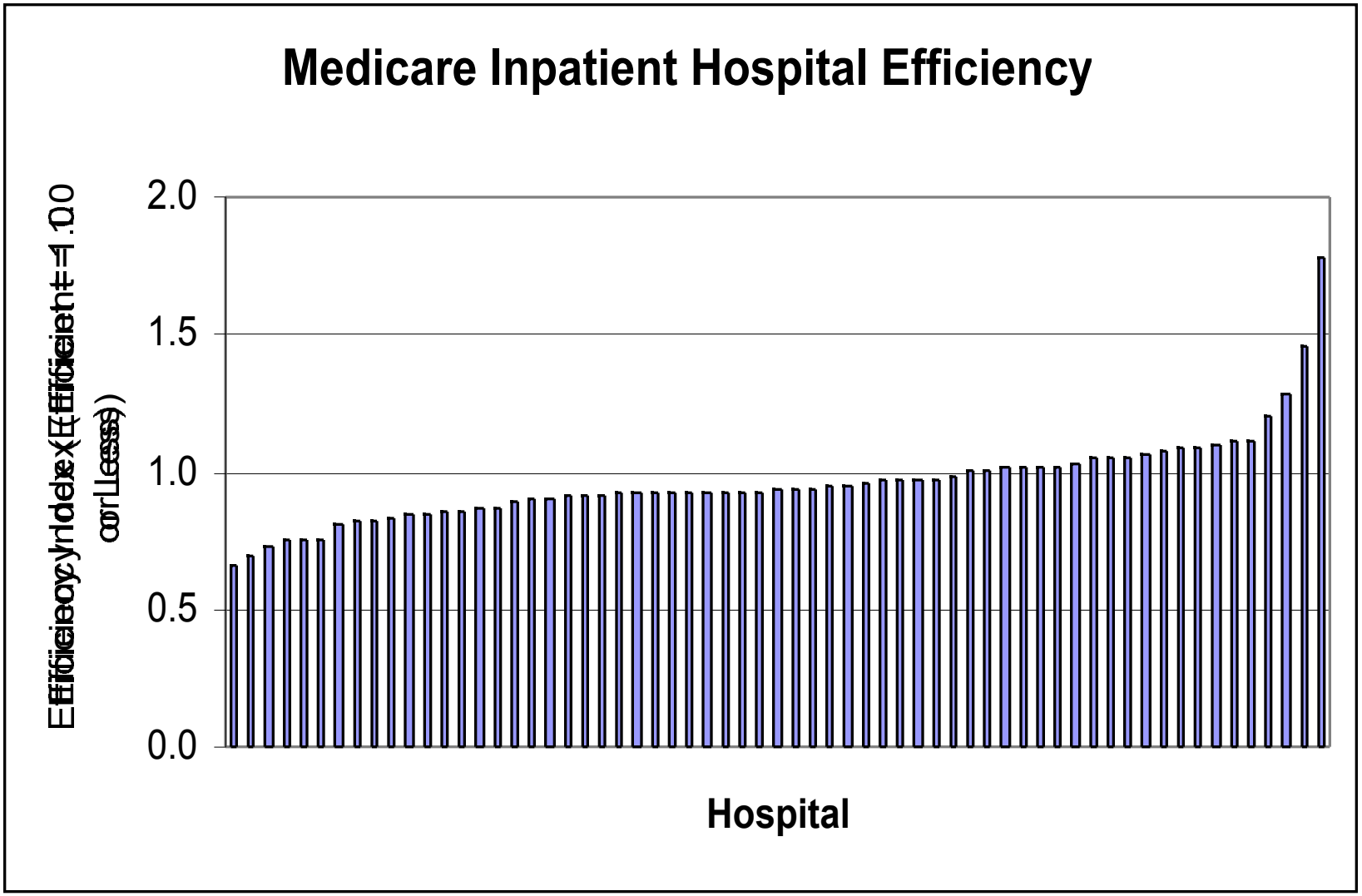
Source: Lewin Group Analysis of DHCFP 403 Cost Report Data.

Medicaid payment to cost ratios, inpatient versus outpatient services, 2000



Source: Lewin Group Analysis of Survey Data Compiled for This Study..

Hospital efficiency analysis, 1998 (Overall ratio of actual to predicted cost = 0.94)



Source: Lewin Group Hospital Efficiency Model.

Massachusetts hospital capacity measures

	MA	MA Rank[2/]	US Average
Beds/1,000 Persons	2.64	36	3.04
Admissions/1,000 Persons	119.7	23	118.7
Average Length of Stay	5.7	29	5.9
InpatientDays/1,000 Persons	681.8	26	703.7
Occupancy Rate [1/]	70.7%	8	63.4%

[1/] Occupancy rate computed using staffed beds.
[2/] Rank is out of 50 states and D.C. The Rank 36 implies that Massachusetts had fewer beds per 1,000 population than 35 other states.
[3/] Statistics are not adjusted for in and out-migration.
Source: American Hospital Association Annual Survey of Hospitals, 1999.

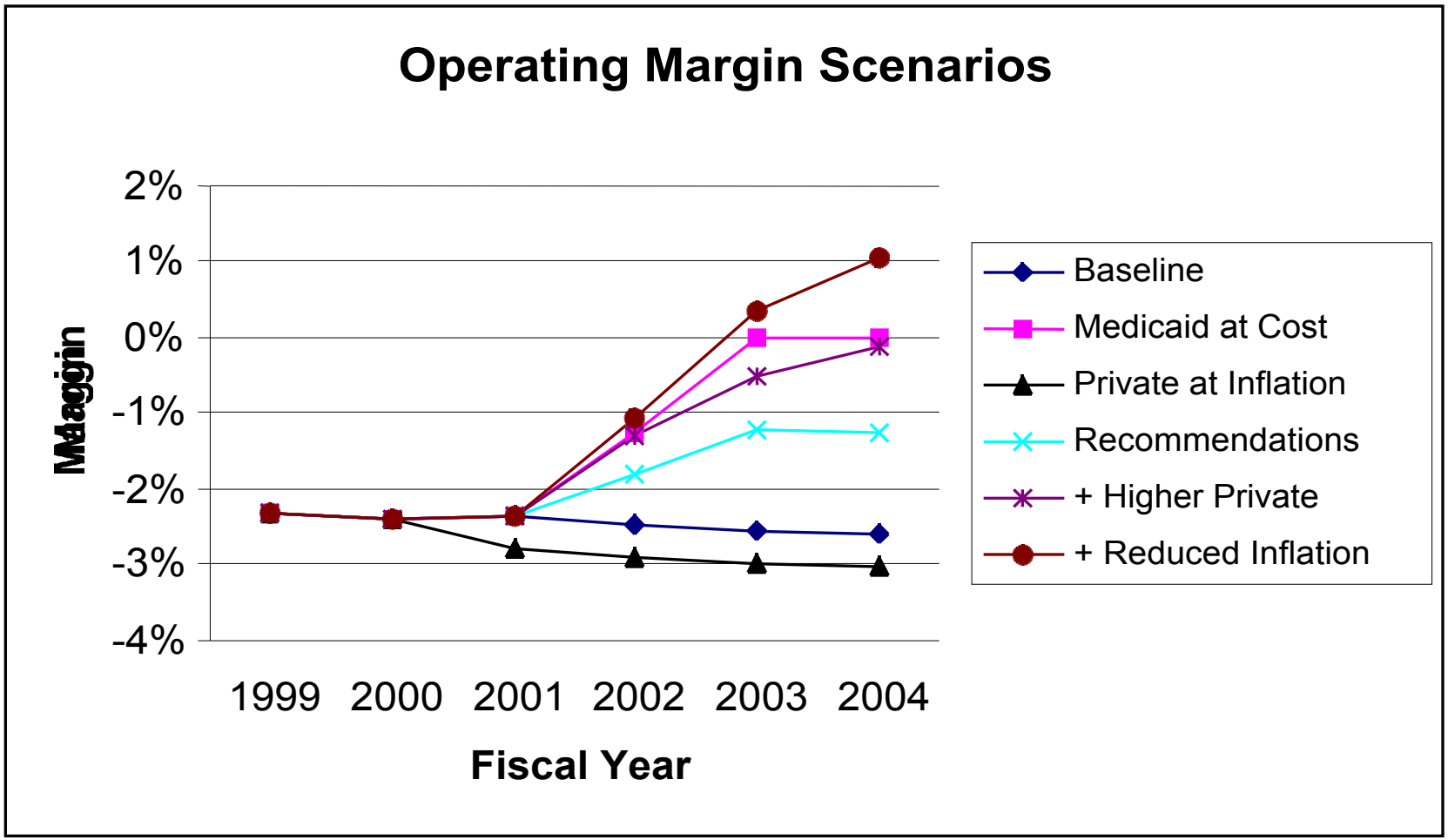
Methods of Covering Medicaid/Low Income Population

- Cost shift
- Overall rate increases
- Targeted rate increases
- Connecticut "solution"
  - Across the board increase in outpatient rates
  - Also payment to cost "floor" established at 0.625
- Our recommendations focus on technical adjustments to payment methodologies (e.g. inflation factors) and higher rates for outpatient services
  - Net effect: $90 million to $120 million for hospitals

Acute hospital recommendations

- Inpatient services (~$38 million to $56 million)
  - Develop standardized rate based on Medicaid (versus all-payer) cost
  - Pay based on current (rather than retrospective) patient acuity
  - Temporarily suspend efficiency adjustment
  - Consider HCFA market basket rather than Consumer Price Index
- Outpatient services (~$53 million to $64 million)
  - Eliminate efficiency adjustment
  - Increase rates for "significant procedure" services
  - Implement Medicare APCs
- Program Administration (~$12.9 million)
  - Consider Third Party Administrator for DRG and APC based systems
  - Initiate planning process to establish or confirm long term goals and strategies

Acute hospital margin projections



Source: Lewin Group Margin Projection Model.

Non-Acute hospital recommendations

- When feasible, implement acuity-based inpatient prospective payment system based on Medicare principles.
- If an acuity-based inpatient PPS cannot be implemented within two years, the inpatient per diem rates should be re-based (updated).
- Study the feasibility of developing a fee schedule payment system for outpatient services in non-acute hospitals.

Community Health Center recommendations

- Conduct analysis of CHC cost reports to estimate center-specific payments required under BIPA.
- Initiate discussions with CHCs over implementation of BIPA requirements.
- Additional analysis of variation in CHC cost per visit is necessary to provide insights into reasonable and appropriate adjustments or limits that might be used when developing a new payment methodology under BIPA.